CHECKLIST

MONTANA BREAST AND CERVICAL HEALTH PROGRAM ANNUAL REVIEW

NOTE: This form is designed to assist administrative sites in preparing for the annual MBCHP review. Please know where these items are, so they can be easily located. This CHECKLIST does not need to be returned. Additional items may be requested at the time of the visit.

1	Administrative Site Review Form completed prior to visit.					
2	pulled	Ten records or 10% of the total number of clients seen, whichever is less, will be bulled for review. (The Quality Assurance Nurse will send list in advance or select charts at arrival.)				
3	Revie	Review of MBCHP Policy and Procedure Manual Complete Current				
4	Forms	orms available:				
	1.	Eligibility and Enrollment form				
	2. Informed Consent and Authorization to Disclose Health Care In					
	3.	Breast and Cervical Screening form				
	4.	Abnormal Breast and/or Cervical Findings				
	5.	Acknowledgement of Refusal to Consent to Diagnostic Tests or Treatment				
	6.	Case Management Service Agreement Plan				

CLIENT RECORD REVIEW (Used by MBCHP staff during review)

Note: Use one review sheet for each record/clerk reviewed. Place an X in the blank to indicate item located on client record. Place an O in the blank to indicate item not located on client record. Place an NA if the item does not apply.

1	Client nan	1e	Date of Birth	ID#			
	Current ad	ldress					
2	Documentation and date of financial eligibility						
3	Informed Consent and Authorization to Disclose Health Care Information form (which acknowledges client participation in MBCHP signed, dated and witnessed)						
	Pap test results recorded and filed correctly Appropriate follow-up and documentation for abnormal test results						
	All screening mammography results are recorded and filed correctly Appropriate follow-up and documentation for abnormal test results						
	Current Pap, pelvic, CBE documented and currentSBE taught and documented						
7	Copies of	all necessary MBCH	P data collection forms				
8	Quality As	ssurance Review:					
	a.	_	o final diagnosis <60 days osis to treatment <60 days				
Referre	d to:		Documentation back from	referral source:			
Date: _			Yes No	_ Date:			
	b.		o final diagnosis <60 days osis to treatment <60 days				
Referre	d to:		Documentation back from	n referral source:			
Date: _			Yes No	Date:			
Comme	ents:						